



NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY

Certification and Attestation for Primary Care Rate Increase

DHCFP
Rates and Cost Containment
1100 E. William St. Suite 101
Carson City, NV 89701
Fax (775) 684-3773

Section I: Instructions

NOTE: This form only needs to be submitted once. It is not necessary to resubmit for each quarter.

- Please complete the information in the sections II and IV or V, sign and return by email: pcprateincrease@dhcfp.nv.gov or fax to the address listed above.
- **Physician Assistants/Nurse Practitioners:** The supervising physician must complete the Statement of Responsibility form, which is provided as Page 2.
- **Physicians:** The Statement of Responsibility form is not required for physicians.

Section II: Provider Information

PROVIDER NAME		BUSINESS NAME (if applicable)	
STREET ADDRESS		CITY	STATE
COUNTY	PROVIDER TELEPHONE NO.	PROVIDER FAX NO.	PROVIDER EMAIL ADDRESS
DESIGNATED CONTACT NAME		DESIGNATED CONTACT PHONE NUMBER	DESIGNATED CONTACT E-MAIL ADDRESS
NPI	MEDICARE NUMBER	STATE LICENSE NUMBER	EIN NUMBER
		TAXONOMY NUMBER	

Check specialty(s) that apply to you:

- ☐ Family Practice ☐ General Internal Medicine ☐ Pediatrics

List any Subspecialties:

Are you a Managed Care Program Provider? ☐ Yes ☐ No

If YES, which health plan(s) do you provide services for? ☐ Amerigroup ☐ Health Plan of Nevada (HPN)

Section III: Information

Section 1902(a)(13)(C) of the Social Security Act specifies that physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine are primary care providers. Those that render evaluation and management codes and services related to immunization administration for vaccines and toxoids for specified codes would be eligible for reimbursement.

As proposed in 42 CFR 447 "Payment for Services," in order to be eligible for the increased payment the following requirements must be met. The provider must:

- Be a physician defined in 42 CFR 440.50, or under the personal supervision of a physician with specialist designation in family practice, general internal medicine and pediatrics or a subspecialty recognized by the **American Board of Medical Specialties, American Board of Physician Specialties, or the American Osteopathic Association**:
- Be board certified in the specialty or subspecialty; or
- Have furnished evaluation and management (E&M) and vaccines services that equal at least 60% of the Medicaid codes billed during the most recently completed Calendar Year.

Section IV: American Board of Medical Certification

Complete this section **only** if you have a certification from the American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA). (Attach copy of certification)

ABMS, ABPS, or AOA Certification effective date(s)	Begin Date:	End Date:
I attest that I have a certification recognized by the American Board of Medical Specialties, American of Physician Specialties, or the American Osteopathic Association in one of the above mentioned primary specialty designations and meet the requirements as required by federal and state regulation to receive the increased payment.		
Signature:	Printed Signature:	Date:

Section V: 60% Attestation

Complete this section only if you do not have a certification from the American Board of Medical Specialties, American Board of Physician Specialties, or the American Osteopathic Association but at least 60% of your total billings are E&M and vaccine administration codes. (Codes are specified by Federal and State Regulation)

Current Enrolled providers only (those who have billing history)

I attest that I am an eligible primary care specialist or subspecialist but I do not have a certification recognized by the American Board of Medical Specialties. I attest that at least 60% of my total billings for the previous calendar year were for the E&M and vaccine administration codes as published in the final federal and state regulation and meet the requirements to receive payment.

New providers only (those who have no billing history)

I attest that I am an eligible primary care specialist or subspecialist but I do not have a certification recognized by the American Board of Medical Specialist. I attest that at least 60% of my total billings **will be** for qualified E&M and vaccine administration codes as published in the final federal and state regulation and meet the requirements to receive the increased payment.

Signature:	Printed Name:	Date:
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FOR DHCFP USE ONLY

<input type="checkbox"/> Certified <input type="checkbox"/> 60%	Certification Verified (attach print-out):	Date Verified:
Forwarded to:	Forwarded to:	Forwarded To:
Staff Signature:	Date:	

Statement of Responsibility

➤ **Physicians are required to submit this form for Physician Assistants/Nurse Practitioners**

Practice Name: _____

Parent Company Name: _____

Address: _____

Phone/Fax: _____

PLEASE PRINT

Please be advised that I, Dr. _____, National
Provider Identification Number (NPI) _____, accept
professional and legal responsibility for the Advanced Nursing Practice
Nurse(s)/Physician Assistant(s) listed below.

Supervising Physician Signature

Date

Please
Check
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Name

Signature

NPI

PLEASE

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